Massachusetts Division of Health Care Finance and Policy

Uncompensated Care Pool PFY03 Utilization Report

December 6, 2003

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Commonwealth of Massachusetts

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Uncompensated Care Pool PFY03 Utilization Report

Statutory Mandate

Chapter 26 of the Acts of 2003, lines 4100-0060, included the following provision to which this report responds.

"...provided further, that the division shall submit to the house and senate committees on ways and means not later than December 6, 2003 a report detailing utilization of the Uncompensated Care Pool; provided further, that the report shall include:

1) the number of persons in the Commonwealth whose medical expenses were billed to the Pool in Fiscal Year 2003;

2) the total dollar amount billed to the Pool in Fiscal Year 2003;

3) the demographics of the population using the Pool, and;

4) the types of services paid for out of the Pool funds in Fiscal Year 2003;

provided further, that the division shall include in the report an analysis on hospitals' responsiveness to enrolling eligible individuals into the MassHealth program upon the date of service rather than charging said individuals to the Uncompensated Care Pool..."

A Word About the Data

This is the second annual report submitted by the Division of Health Care Finance and Policy (DHCFP) on utilization of the Uncompensated Care Pool (the Pool), and covers Pool Fiscal Year 2003 (PFY03).[1] As required by statute, this report provides information on the number of individuals using the Pool, the total dollar amount billed to the Pool, the demographics of Pool users, and the types of services paid for by Pool funds during PFY03.

The data used for this report include eligibility and demographic data on individuals applying for free care, and claims data on the clinical services paid for by the Pool. Eligibility data are collected by DHCFP's electronic application software, and claims data are submitted in UB-92 claims format by each provider. Consistency and validity of the data are ensured through a series of quality edits applied to the data. In addition, free care claims are matched to their corresponding free care application in order to verify the legitimacy of the claim. DHCFP also takes special steps to ensure that it can identify an unduplicated number of Pool users by using sophisticated algorithms and matching patient identities across providers. Further information on the data is provided in Appendix A.

Because there is a three-month lag in reporting requirements, the claims and eligibility database used for this report contains data only for the first ten months of the Pool year (October 1, 2002 through July 30, 2003). When appropriate, values for the full year have been extrapolated from the data and are noted in the report.

[1] The 2003 Pool Fiscal Year (PFY03) runs from October 1, 2002 through September 30, 2003. Any claims billed to the Pool during that time, or free care applications used to determine an individual's eligibility during those months, are considered to be PFY03 data.

Number of Individuals Served by the Pool[2]

In PFY03, medical expenses for an estimated 389,909 individuals[3] were billed to the Uncompensated Care Pool.[4,5] Charges for services for 198,854 (51%) of these individuals were submitted to the Pool by hospitals as regular free care for which the Pool was the primary payer for 165,049 (83%).[6] Charges for another 132,569 (34%) individuals were submitted by hospitals as emergency bad debt (ERBD), while bills for 58,486 (15%) individuals were submitted by freestanding community health centers.

[2] The total numbers for PFY03 are extrapolated from 10 months of data.

[3] These individuals include Massachusetts residents who received medically necessary care, as well as out-of-state residents who received urgent and emergency services charged to the Uncompensated Care Pool.

[4] Figures reported in this section are the result of a method that is designed to produce unduplicated counts from the data submitted by providers. In order to avoid double counting among types of claims (e.g., ERBD, inpatient, etc.), users were assigned to the category of the most recent claim submitted for services used by that patient.

[5] Caution should be taken when comparing this Pool user count with a count of the number of uninsured individuals in the Commonwealth based on survey results. The Commonwealth's survey, like most surveys of the uninsured, asked whether an individual was uninsured on a particular date, rather than whether the individual had been uninsured at any point during a one-year period.

[6] The Pool is the secondary payer when another public or private insurer is the principal or primary payer; the balance for which the eligible low-income patient is responsible can then be charged to the Pool.

Total Amount Billed to the Pool

In PFY03, a total of approximately $941[7] million in free care charges was billed to the Uncompensated Care Pool by hospitals and community health centers (CHCs). Of this, $912.2 million was billed by hospitals and $28.7 million was billed by CHCs.

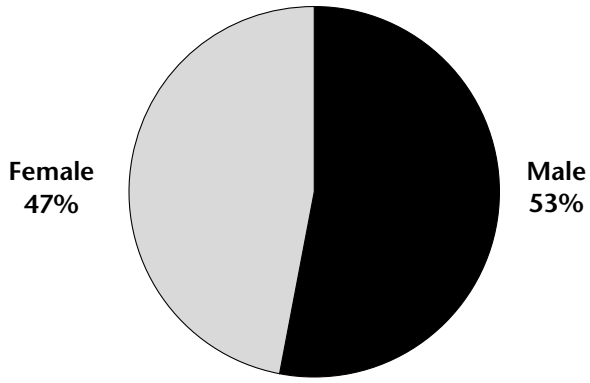
The $912.2 million in hospital free care charges represents $536.6 million in allowable free care costs. The Uncompensated Care Pool pays these allowable free care costs to the extent that funding is available. For more details and comparisons across fiscal years, refer to Appendix B. For an explanation of the difficulties in projecting Pool expenses, see Appendix C.

[7] This estimate is an extrapolation from the first 10 months of data. For the actual amounts from the 10 months, see Figure. 6.

Pool User Demographics[8]

The eligibility and clinical services databases provide information about the characteristics of the individuals who relied on the Pool to cover the costs of their health care needs during PFY03. As the data on the following pages indicate, the majority of Pool users were single, childless adults ages 19 to 64, with very low incomes.

Percent of Total Charges to the Pool by Gender, PFY03



Source: DHCFP Uncompensated Care Pool claims data

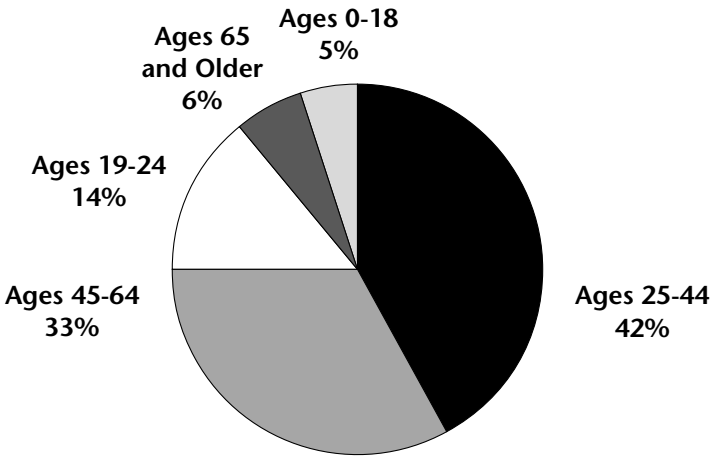
Slightly more than half of the charges to the Pool[9] were for male users.

Figure 1

[8] For additional information on Pool data sources, see Appendix A.

[9] Charges to the Pool include charges for both free care and emergency bad debt (ERBD). The charges are net of payments made by other payers, or other third party liability recoveries. The Pool is always the payer of last resort.

Percent of Total Charges to the Pool by Age Group, PFY03

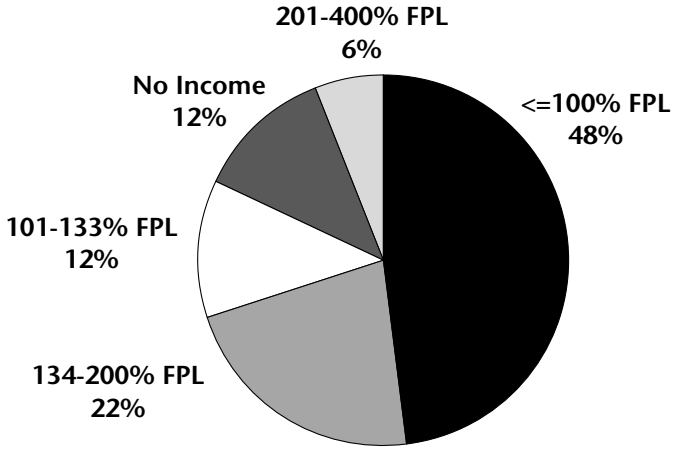


Source: DHCFP Uncompensated Care Pool claims data

The greatest share of charges to the Pool was for young adults ages 25 to 44. Eighty-nine percent (89%) of charges were for the entire non-elderly adult population ages 19 to 64. Males ages 25 to 44 generated the largest share of charges (23%).

Figure 2

Percent of Total Charges to the Pool by Family Income*, PFY03

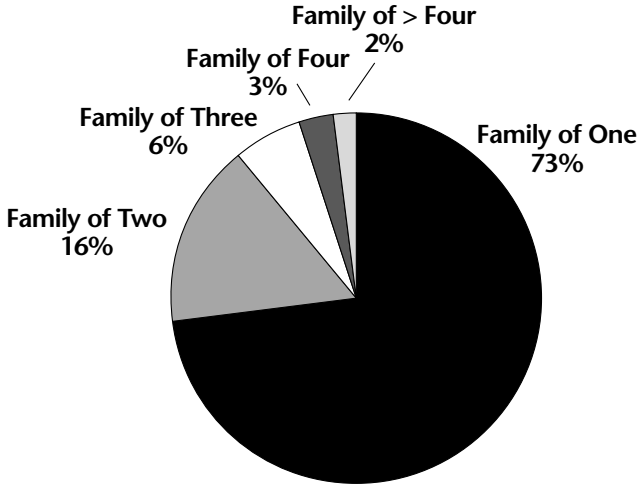


Source: DHCFP Uncompensated Care Pool claims and eligibility data
*Includes only claims that are matched to a free care application, and therefore excludes ER bad debt claims (for which there are no applications).

The majority of free care dollars (60%) were spent on individuals whose family income fell at or below the federal poverty level.

Figure 3

Percent of Total Charges to the Pool by Family Size*, PFY03

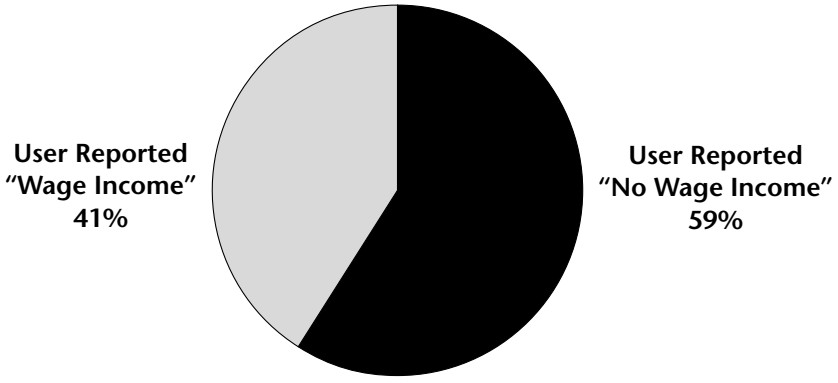


Source: DHCFP Uncompensated Care Pool claims and eligibility data
*Includes only claims that are matched to a free care application, and therefore excludes ER bad debt claims (for which there are no applications).

Seventy-three percent (73%) of charges to the Pool were generated by single individuals and an additional 16% were generated by two-person families, comprised of two adults or an adult and child. Combined, one- and two-person families generated 89% of charges to the Pool.

Figure 4

Percent of Charges to the Pool by User's Self-Reported Employment Status*, PFY03



Source: DHCFP Uncompensated Care Pool claims and eligibility data
*Includes only claims that could be matched to free care applications.

More than half (59%) of the charges to the Pool were for services to individuals who reported "no wage income."

Figure 5

Services Paid for by the Pool

Claim Count and Charges to the Pool by Type of Claim, PFY03 (October 2002 – July 2003)

	Claim Count	Percent	Total Charges to the Pool (excluding CHCs)	Percent
Total Claims	**1,441,403**	**100%**	**$877,127,381**	**100%**
Total Inpatient Claims	35,267	2%	$340,402,768	39%
Total Outpatient Claims	1,406,136	98%	$536,724,613	61%
Total CHC Claims	221,784	15%	na	na
Total ERBD Claims	195,750	14%	$165,027,747	19%
Total Regular FC Claims	1,245,653	86%	$712,099,635	81%
Total Outpatient Claims	**1,406,136**	**100%**	**$536,724,613**	**100%**
Outpatient Pharmacy[10]	292,146	21%	$50,219,104	9%
Outpatient ER Claims	266,921	19%	$187,126,843	35%
Outpatient Clinic Claims	435,509	31%	$106,720,648	20%
Outpatient Ambulatory Surgery Claims	15,601	1%	$41,441,212	8%
Other Outpatient Claims	395,959	28%	$151,216,805	28%

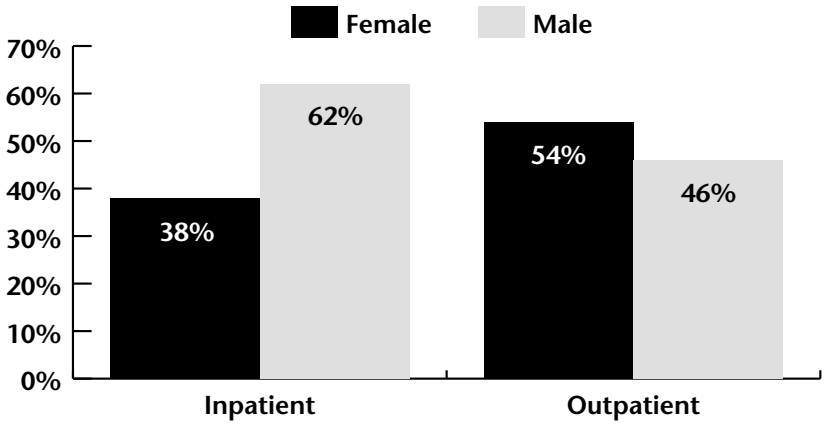
This table summarizes the PFY03 patient-level clinical services data currently available in the DHCFP database (i.e., the first 10 months of PFY03). These data, submitted to DHCFP in a UB-92 claim format, represent approximately 90% of all allowable free care charges billed to the Pool by hospitals on their monthly forms.

Although only 2% of claims submitted to the Pool were for inpatient services, charges for these services represented 39% of the total charges to the Pool. The majority (84%) of Pool claims were for outpatient services, but these claims represented 61% of charges to the Pool. The remaining 13% of all claims were generated by CHCs. Claims for emergency bad debt (ERBD) represented 14% of all Pool claims and 18% of total charges to the Pool.

Figure 6

[10] Outpatient pharmacy claims are identified in the database as any outpatient claim in which there are *only* pharmacy charges, as indicated by a pharmacy revenue code. If a pharmacy charge occurs along with other services (i.e., ER, ambulatory surgery, clinic), it is included within the charges for that service. No details on the type of medication are available on the claim.

Percent of Charges to the Pool by Type of Claim and Gender, PFY03

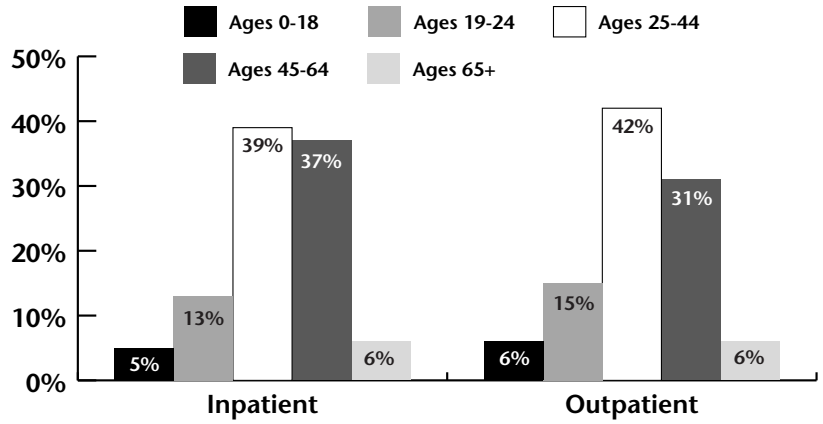


Source: DHCFP Uncompensated Care Pool claims data

Services for males generated a significantly larger proportion of inpatient charges, while services for females represented slightly more of the outpatient charges.

Figure 7

Percent of Charges to the Pool by Type of Claim and Patient Age, PFY03

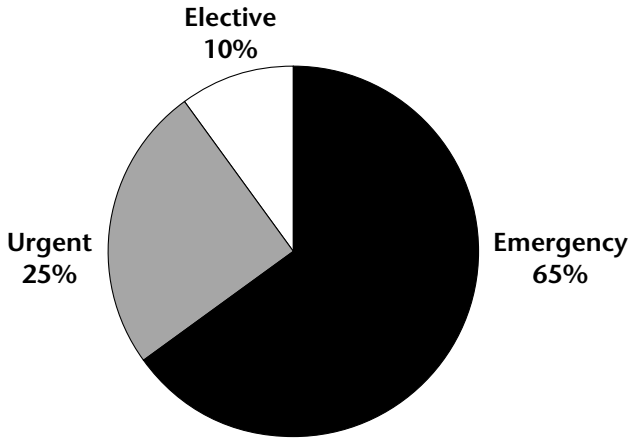


Source: DHCFP Uncompensated Care Pool claims data

Pool users ages 25 to 64 represented the majority of both inpatient and outpatient charges to the Pool.

Figure 8

Percent of Inpatient Claims by Admission Type*, PFY03



Source: DHCFP Uncompensated Care Pool claims data
*Admission type excludes patients with pregnancy-related diagnoses (MDC 14 and 15).

Almost two thirds (65%) of free care inpatients are admitted as emergencies, a quarter (25%) for urgent care, and a smaller share (10%) for elective procedures. It is important to note that "elective" indicates that the service was scheduled ahead of time; it does not indicate that the service was not medically necessary. For example, most surgeries to remove cancerous tumors are scheduled, and thus characterized as elective procedures.

Figure 9

Inpatient Major Diagnostic Category[11] for Free Care Patients, PFY03 (percent of total charges)

Pool Rank	MDC	Percent
1	Circulatory System	18%
2	Mental Diseases and Disorders	10%
3	Digestive System	10%
4	Musculoskeletal System and Connective Tissue	8%
5	Alcohol/Drug Use Related Mental Disorders	7%
6	Respiratory System	7%
7	Nervous System	7%
8	Hepatobiliary System and Pancreas	5%
9	Kidney and Urinary Tract	3%
10	Injuries, Poisonings and Toxic Effects	3%
	Total for 10 Ten MDCs	**78%**

Discharges for circulatory diagnoses represented the largest share of inpatient charges for free care patients. Taken together, discharges with a primary diagnosis of mental health or alcohol/drug use related mental disorders represented the second most common type of discharges (17%).

Figure 10

[11] Inpatient diagnoses are classified into one of twenty-five major diagnostic categories (MDC). Discharges are grouped into MDCs using 3M's All Patient DRG Grouper, version 12.

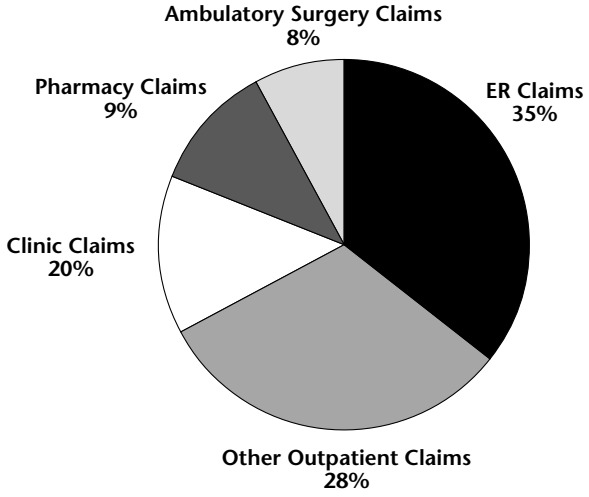
Characteristics of the Inpatient Free Care Population, PFY01 to PFY03

	PFY01	PFY02	PFY03
Case Mix Index	1.37	1.49	1.68
Average Length of Stay	4.78 days	4.44 days	5.63 days

The case mix index represents the amount of resources required to treat a given population. It is implied that the level of resources a patient requires is an approximation of their acuity level (i.e., level of illness). A case mix index of 1.00 suggests a given patient uses an average amount of resources, while a case mix of 2.00 implies a patient requires double the amount of resources. According to this table, free care patients used more resources, on average, each year compared with the previous year. In addition, the average length of stay increased significantly from PFY02 to PFY03, after a slight decrease in the previous year. The length of stay may indicate that the general level of illness of the Pool population is increasing, or that the population includes more sick individuals.

Figure 11

Percent of Charges to the Pool by Outpatient Service Type*, PFY03



Source: DHCFP Uncompensated Care Pool claims data
*Outpatient pharmacy claims are claims with charges for pharmacy only. Pharmacy charges that occur with other services would be included in one of the other categories.

The largest proportion of outpatient charges to the Pool was for ER services (35%). Another 20% of outpatient charges were for clinic services. "Other outpatient claims" include charges for ancillary services that may have been provided in conjunction with an emergency, ambulatory surgery, or clinic visits, but were billed separately.

Figure 12

Hospital Responsiveness to Enrolling Patients in MassHealth

DHCFP regulations require acute hospitals and free-standing community health centers (CHCs) to screen patients for other sources of coverage and potential eligibility in government programs before approving them for free care. Hospitals and CHCs are required to document the results of each screening.

If a provider determines that a patient may be eligible for Medicaid or another government program, the provider shall "encourage the patient to apply for such program and shall assist the patient in applying for benefits under such program. A patient who declines to apply for another government program may apply and, if eligible, be approved for free care." (114.6 CMR 10.04 (2))

The free care application software requires providers to report a patient's MassHealth status as part of the screening process. For instance, the provider must indicate if a free care applicant is a MassHealth enrollee or if a MassHealth eligibility determination is pending. DHCFP audit work has found that providers have been complying with DHCFP's MassHealth screening requirements, and that they do assist patients with the MassHealth application process. In addition, the free care application links directly with the MassHealth recipient eligibility and verification system (REVS). REVS allows the provider to search the MassHealth enrollment database to verify a patient's MassHealth enrollment.

Federal statutes do not require patients to apply for MassHealth; therefore, not all patients who may be eligible for MassHealth choose to apply. Also, during PFY03, MassHealth Basic was terminated as of March 31, 2003, causing many former MassHealth beneficiaries to turn to the Pool to cover their health care costs. A new benefit package, MassHealth Essential, began as of October 1, 2003 (PFY04) with some eligibility changes from MassHealth Basic.

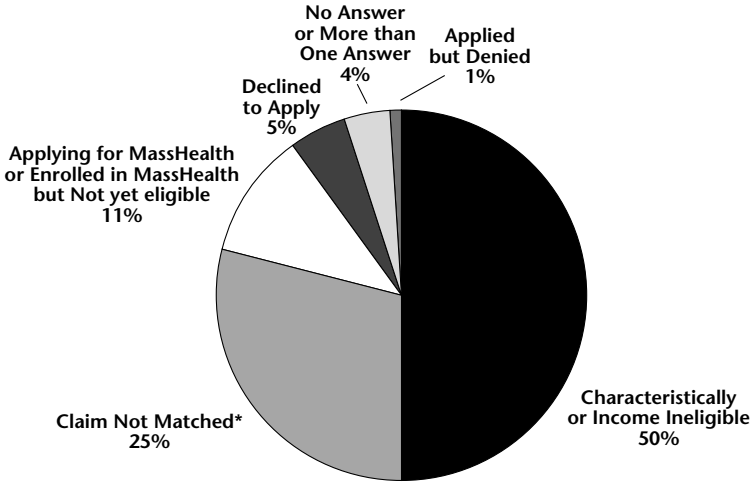
The Pool pays for patient care under many different circumstances. The largest group of Pool users is low-income, uninsured individuals who are ineligible for MassHealth; this group represents at least 50% of charges to the Pool (see Figure 13). For low-income individuals, the Pool also pays for:

- services not covered by other programs (e.g., MassHealth Limited and Children's Medical Security Plan);
- services provided prior to MassHealth eligibility dates;
- services provided to patients who apply for MassHealth too late to cover their service date, even though they may have been eligible prior to the date of service;
- patients who decline to apply for MassHealth or other programs which might otherwise have been responsible for paying for the services;
- balances after insurance for private patients;

- balances after insurance for Medicare patients;
- seniors ineligible for Medicare;
- bad debt resulting from emergency services provided to uninsured patients (patients for whom no application form was completed);
- partial free care for individuals with incomes 200-400% FPL; and
- patients whose medical expenses in one year are large enough to qualify as 'medical hardship.'

Using demographic information provided on the free care application, the Division of Health Care Finance and Policy has developed an algorithm to identify Uncompensated Care Pool users who appear to be potentially eligible for a MassHealth program. Although the information is not sufficient to make an eligibility determination, it is sufficient to identify individuals who are clearly ineligible and to categorize those who appear to be potentially eligible for one of the programs.

Percent of Charges to the Pool Based on MassHealth Screening Results, PFY03

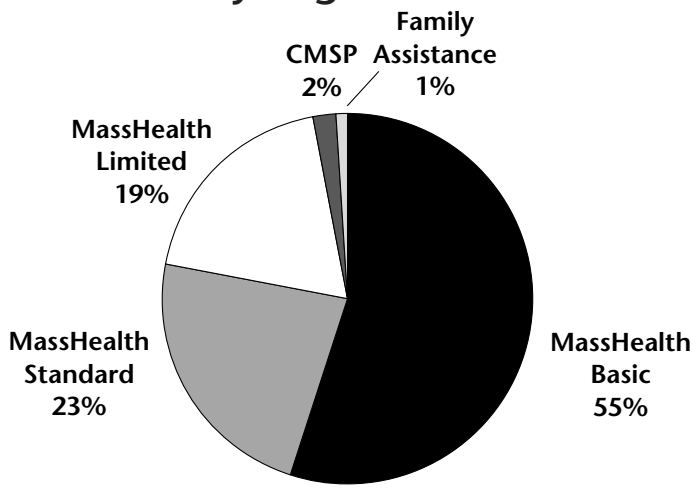


Source: DHCFP matched claims and application database
*See Appendix A.

At least half of all charges to the Pool can be attributed to individuals who were ineligible for MassHealth because they were "over-income" or categorically ineligible. Another 5% of charges were for those who may have been eligible for a MassHealth program, but did not to apply.

Figure 13

Percent of Charges to the Pool by Program for Patients Potentially Eligible for MassHealth*, PFY03

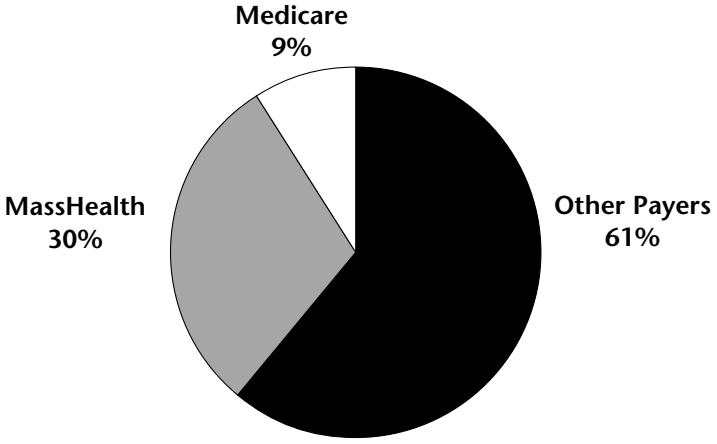


Source: DHCFP matched claims data
*Includes only Pool users who appear to be eligible for MassHealth or other programs, and is limited to patients who were eligible for full free care where the Pool was the only payer.

Of those who appeared to be potentially eligible, 55% of charges were for users who appeared to be eligible for MassHealth Basic, and another 23% of charges were for those who appeared to be eligible for MassHealth Standard. The percentage of Pool users who appeared to be eligible for MassHealth Basic decreased by 25% from last year, not because of any significant changes in the population, but because the program itself was drastically curtailed as of March 31, 2002. Therefore, individuals who last year would have been identified as being potentially eligible for MassHealth Basic had no other options but the Pool as of April 1, 2003.

Figure 14

Percent of Charges to the Pool by Payer when Pool Is Secondary Payer, PFY03



Source: DHCFP Uncompensated Care Pool claims data

The Pool was the primary payer for 89% of claims, but also acted as a secondary payer for underinsured low-income individuals by providing wrap-around payments and coverage for copayments, and deductibles. For the 11% of claims in which the Pool was the secondary payer, most of the charges to the Pool (60%) went to provide additional coverage for privately insured patients. Another third (30%) of these charges provided additional coverage for MassHealth patients and 9% for Medicare patients.

Figure 15

Appendix A: Data Notes

Data used in this analysis were drawn from the following sources:

Pool Claims Database

Hospitals and CHCs began electronic submission of data elements in UB-92 claims format to the Division of Health Care Finance and Policy in March, 2001. During PFY03, DHCFP began penalizing hospitals with incomplete data. As a result, compliance with data submission requirements has improved dramatically, and although variability exists among providers, the charges to the Pool reported in the claims database equal approximately 90% of the charges reported by hospitals in their monthly statements submitted to DHCFP for payment purposes.

Pool Applications Database

Hospitals and CHCs began submitting electronic free care application forms to DHCFP in October 2000. Note that the application contains data as reported by the applicant, with documentation required from the applicant to verify income and residency.

Matched Pool Applications and Claims Database

To the extent possible, DHCFP matches free care claims to the corresponding free care application. Matching is based on social security number or tax identification number when available. Additional matching uses an algorithm based on other available data such as phonetic last name, phonetic first name, date of birth, provider, etc. Because there are no applications associated with emergency bad debt (ERBD) claims, ERBD claims data are excluded from the match. Approximately 82% of claims data have been matched to applications.

Appendix B: Sources and Uses of Pool Funds (in millions)

Sources of Funds	**PFY99**	**PFY00**	**PFY01**	**PFY02**	**PFY03**	**PFY04**
Uncompensated Care Pool						
Hospital Assessment	$215.0	$215.0	$215.0	$170.0	$170.0	$157.5
Surcharge on Payments to Hospitals	100.0	100.0	100.0	100.0	100.0	$157.5
State Appropriation	30.0	30.0	30.0	30.0	45.0	140.0
Total Uncompensated Care Pool	345.0	345.0	345.0	300.0	315.0	455.0
Other Funds						
Intergovernmental Transfer (IGT)	70.0	70.0	70.0	70.0	70.0	120.0
c.495 §56 Compliance Liability Funds		15.0	1.1			
Prior Fiscal Year Surplus Transfer		9.0				28.0
Transfer from Medical Security Trust Fund		15.0	25.0	90.0		
Transfer from the Tobacco Settlement Fund				12.0	30.0	
Transfer from Jobs and Growth Tax Relief Fund						55.0
Transfer from the General Fund						35.0
Total Sources of Funds	**415.0**	**454.0**	**441.1**	**472.0**	**415.0**	**693.0**
Uses of Funds						
Payments						
Hospital Free Care Costs	381.9	396.8	410.6	442.9	536.6	578.1
CHC Free Care Costs	14.5	15.7	17.7	22.5	28.7	28.0
Transfer to Children's and Seniors' Health Care Assistance Fund	11.8	46.3	44.3	33.8		160.0
Reserves and Expenses (inc. Demonstration Projects)	3.0	5.9	6.8	11.5	7.5	5.0
Total Uses of Funds	**411.0**	**465.0**	**479.0**	**511.0**	**573.0**	**771.0**
(Shortfall) / Surplus	**3.9**	**(10.7)**	**(38.3)**	**(38.6)**	**(157.9)**	**(78.1)**

Notes: Calculations presented are as of November 3, 2003.
Amounts are subject to change at Final and/or Interim Settlement.
Reserves and Expenses include funds set aside for Demonstration Projects.

Appendix C: Challenges in Projecting Free Care Costs

The Division of Health Care Finance and Policy projects free care costs and Uncompensated Care Pool shortfalls or surpluses on a regular basis. Projecting free care costs is extremely difficult because of the large number of factors that can affect final amounts. These factors are discussed below.

First, the Pool is the payer of last resort. The Pool pays for any medically necessary service provided by an acute hospital or community health center to a low-income uninsured or underinsured person that is not covered by another payer. Therefore, if there are any changes in enrollment or services covered by any other public or private payer, the changes will affect the Pool. Changes in other programs, such as MassHealth, often are not announced publicly until after they have taken effect, and even then, it is very difficult to quantify the direct impact that the change will have on the Pool.

Second, because most private insurance is accessed through employment, changes in employment levels, types of employees hired (full-time versus contracted or part-time), and/or the level of benefits offered will affect the Pool.

Third, the Pool is required by law to pay providers on a fee-for-service basis. If the amount a provider bills to the Pool increases by 50% in a particular month, the Pool must reimburse the hospital for the increased amount. A provider may bill higher amounts for many reasons: expanded services, increased volume, an epidemic, installation of a new billing system, and so on.

Finally, the Pool is not a program, and it does not enroll members. The Division of Health Care Finance and Policy cannot project costs based on enrollment per member per month (PMPM) multiplied by cost per member per month as health plans do. In addition, many people apply for free care after they have received a service. Up through PFY03, the Pool had not implemented preadmission certifications and other methods of utilization review, and as a result, the Division of Health Care Finance and Policy has not gotten advance warning of high-cost procedures being billed to the Pool.

Source: Uncompensated Care Pool PFY01 Annual Report, Section 6, August 2002.

Production Notes

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